# PROCEDURE FOR PRESSURE ULCER PREVENTION AND MANAGEMENT

<table>
<thead>
<tr>
<th>Issue History</th>
<th>Issue Version</th>
<th>Purpose of Issue/Description of Change</th>
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<td>One</td>
<td>To outline evidence based practice for the Prevention and Management of Pressure Ulcers</td>
<td>2013</td>
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**Named Responsible Officer:**
- Quality and Governance Service
- Tissue Viability Specialist Nurse

**Approved by:**
- Risk and Governance Group

**Date:** August 2011

**Target Audience:**
- Community Nursing and Specialist Nurses

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UNLESS THIS VERSION HAS BEEN TAKEN DIRECTLY FROM THE TRUST WEB SITE THERE IS NO ASSURANCE THIS IS THE CORRECT VERSION
**CONTROL RECORD**

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<td>To outline evidence based practice for the Prevention and Management of Pressure Ulcers</td>
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<tr>
<td>Author</td>
<td>Tissue Viability Team Quality and Governance Service (QGS)</td>
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<td>Impact Assessment</td>
<td>Completed</td>
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<td>Subject Experts</td>
<td>Ian Mansell / Ann Baker / Claire Wedge</td>
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<tr>
<td>Document Librarian</td>
<td>QGS</td>
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<tr>
<td>Groups consulted with :</td>
<td>Clinical Policies and Procedures Group</td>
</tr>
<tr>
<td>Date formally approved by Risk and Governance Group</td>
<td>6th July 2011</td>
</tr>
<tr>
<td>Infection Control Approved</td>
<td>Yes 16th June 2011</td>
</tr>
<tr>
<td>Method of distribution</td>
<td>Email ✔</td>
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<tr>
<td>Archived</td>
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**VERSION CONTROL RECORD**

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<td>Tissue Viability Specialist Nurse</td>
<td>R/TC</td>
<td>Responsibilities clarified when joint care package in place with a Care Home</td>
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PROCEDURE FOR PRESSURE ULCER PREVENTION AND MANAGEMENT

INTRODUCTION

Pressure ulcers represent a major source of distress for patients in terms of physical, social and financial implications, as well as affecting quality of life for patients and their carers. Nurses will follow this procedure to prevent pressure ulcer development for those at risk and to reduce the occurrence of pressure ulcers for patients on the Wirral. The principles are based on clinical guidelines recommended by the National Institute of Clinical Evidence (NICE 2005), the Royal College of Nursing (RCN 2001), and Commissioning for Quality and Innovation (DH 2008).

AIM

- To ensure that all patients receive evidenced based care for the prevention and management of pressure ulcers
- All patients with a Grade Two Pressure Ulcer have a Trust incident form completed as per NICE Guidelines (NICE 2005).

COMPLETION OF PRESSURE ULCER DOCUMENTATION

When nurses are assessing patients and completing Initial Assessment Community Nursing Documentation, there is a section for nurses to assess patients at risk of pressure ulcer development. To guide and enable nurses to complete the relevant documentation there are flow charts at the end of this procedure in the appendix section:

- Appendix 2 Flow Chart 1 - For the Prevention of Pressure Ulcers
- Appendix 3 Flow Chart 2 - For the Assessment and management of patients with existing or new pressure ulcers

The flowcharts highlight all current documentation

TARGET GROUP

All Community Nurses and Assistant Practitioners employed by the Trust who are required to deliver pressure ulcer prevention and care management.

RELATED TRUST POLICIES AND PROCEDURES

Please refer to related policies and procedures

EDUCATION AND TRAINING

All nurses will attend current Core Clinical Training Programme for Tissue Viability, a two day course covering:

- pressure ulcer prevention and management
- wound dressing selection
- aetiology of chronic wounds

Compliance monitoring is 80% attendance
**DEFINITION OF A PRESSURE ULCER**
A pressure ulcer is localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear. A number of contributing or confounding factors are also associated with pressure ulcers; the significance of these factors is yet to be elucidated (EPUAP 2009).

**INTRINSIC FACTORS**
There are a number of intrinsic factors, which contribute to the development of tissue damage which should be considered during the assessment.

<table>
<thead>
<tr>
<th>Increasing age</th>
<th>Reduced mobility</th>
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</thead>
<tbody>
<tr>
<td>Chronic illness</td>
<td>Neurological deficit</td>
</tr>
<tr>
<td>Poor oxygen perfusion</td>
<td>Poor nutritional intake and dehydration</td>
</tr>
<tr>
<td>Body weight (thin/obese)</td>
<td>Incontinence</td>
</tr>
<tr>
<td>Major surgery</td>
<td>Acute illness</td>
</tr>
<tr>
<td>Terminal illness</td>
<td>Psychological factors</td>
</tr>
<tr>
<td>Level of consciousness</td>
<td>Long term conditions e.g. diabetes</td>
</tr>
</tbody>
</table>

**EXTRINSIC FACTORS**
The extrinsic factors involved in the development of pressure ulcers are:
- Pressure
- Friction
- Shearing
- Moisture
- Medication

**ASSESSMENT**
All patients who are deemed to be at risk of pressure ulcer development are assessed using formal assessment methods to determine their level of risk of pressure ulcer development. When completing pressure ulcer assessment documentation the nurse will need to complete a body map chart that correlates with the assessment documentation using a numbering system e.g. 1, 2, 3. Clinical assessment needs to include routine medical history, physical and psychosocial history and patient preferences and the following documentation need to be completed:

**Patients at risk** – Follow Flow chart 1- Prevention of Pressure Ulcers (Appendix 2)

**Patients with existing or new pressure ulcers** – Follow Flow chart 2 - the Assessment and Management of Patients with Existing or new pressure Ulcers (Appendix 3)

The European Pressure Ulcer Advisory Panel (EPUAP – Appendix One of this document) classification tool should be utilised when assessing the extent of tissue damage. This will provide a formalised specific and valid grade of tissue damage. This will aid in determining appropriate pressure redistribution equipment and suitable sterile dressings, as well as influencing the patients 24 hour care needs.

Formal risk scales should be used in conjunction with clinical judgement (NICE 2005). This enables staff to formulate an individualised care plan identifying pressure-reducing measures which should take into consideration the care setting that the patient is being cared for in.
A holistic wound assessment is needed to decide the most appropriate methods of wound management and dressing selection.

CARE HOMES
Patients living in a Care Home who are funded for residential care may require nursing care from the Community Nursing Service.

Following assessment for the management of pressure ulcers, community nurses must discuss with the manager / duty manager at the Care Home the level of care required by the home care staff to prevent and/or manage pressure ulcers in between community nurses visits.

Community nurses must document the expected level of shared care for the patient on a care plan for Care Home staff to follow; this may include advice on frequency of repositioning, manual handling and the skin integrity check list. Community nurses must review and reassess care at least weekly and document any deviations from care in the patient’s health records.

Community nurses must liaise with the Care Home manager at stated periods as defined by care plan, e.g. weekly, fortnightly etc. The minimum contact is monthly.

If the Care Home does not deliver the agreed shared care arrangements despite discussions with Care Home manager, Trust nurses will complete an incident form and the nurse will refer to the Safeguarding Team if appropriate.

If the Care Home cannot meet the needs of the patient for the prevention and management of pressure ulcers the community nurse will inform the manager of the Care Home that the nurse will be discussing the level of care required for the patient with their line manager, to discuss potential alternative arrangements for care.

DRESSING SELECTION
Decisions about choice of dressing or topical agent for those with a pressure ulcer should be based on:
- Ulcer assessment
- General skin assessment
- Treatment objectives
- Previous positive effect of dressing/technique
- Manufactures indications for use and contra-indications
- Risk of adverse events
- Patients preference
- Wirral wound dressing formulary

Create an optimum wound healing environment by considering the use of modern dressings (for example, hydrocolloids, hydrogels, foams, films, alginates)

Consider anti-microbial therapy in the presence of systemic and/or local signs of infection (Trust Antibiotic Formulary)
WOUND RE-ASSESSMENT
Reassessment of the ulcer should take place as a minimum weekly but maybe required more frequently, depending on the condition of the wound and the result of holistic assessment of the patient.

For wounds that do not show evidence of healing within 4-6 weeks refer to a tissue viability specialist nurses (TVN) for advice and support and a joint visit if required.

If required, discuss with multidisciplinary team for possible referral for surgical intervention, surgery is not usually indicated in patients who have grade 1 or 2 pressure ulcers. It is usually used as an intervention in those with grade 3 or 4 pressure ulcers.

For patients at risk of pressure ulcers or have healed pressure ulcers reassessment for pressure ulcer equipment should be at least every three months for as long as it is required. The ordering officer for the equipment has the responsibility for the monitoring of the patient and need for equipment.

PHOTOGRAPHY
Following European Pressure Ulcer Advisory Panel (EPUAP 2009) recommendations, Trust health professionals will reassess and map ulcers using photographs every 2-4 weeks. All nursing teams will have access to this equipment, and any problems accessing equipment to be raised with line manager.

Health professionals must obtain consent for the use of photographs, for each episode of care, using Trust Consent for Photography Form, available on the Trust intranet.

Photographs of the pressure ulcer will be printed, one copy for the patient’s records and one copy for the base notes, identifying the image with the patient’s full name, date of birth and NHS Number. No digital images must be stored on individual computers.

WOUND DEBRIDEMENT – (Refer to: Procedure for Conservative Sharp Debridement)
Debridement involves the removal of dead or necrotic tissue, or other debris, from the wound to reduce the wound’s biological burden. A number of terms are used to describe dead tissue in wounds: necrosis, slough and eschar.

Clinicians should recognise the positive potential benefit of debridement in the management of pressure ulcers. Decisions about the method of debridement should be based on:

- Ulcer assessment (condition of wound)
- General skin assessment
- Previous positive effects of debridement techniques
- Manufactures indications for use and contra-indications
- Risk of adverse events
- Patient preference (lifestyle, abilities and comfort)
- Characteristic of dressing/technique
- Treatment objectives

The sharp debridement of loose, devitalised tissue must only be carried out by tissue viability specialist nurses. Contact the TVN if debridement is required.
NUTRITIONAL STATUS
All patients at risk of pressure ulcer development will be assessed by completing Pressure Ulcer and Nutrition Risk assessment Form. Staff must refer to the current Trust Protocol for Best Practice in the Identification and Treatment of Malnutrition in Adults. A generic Nutritional Care Plan must be initiated for medium or high risk patients. All documents are available on Trust intranet.

Malnutrition is frequently cited as a risk factor for the presence, development and non-healing of pressure ulcers. Best practice entails monitoring the nutritional status of individuals as part of a holistic assessment and as an ongoing process throughout an individual’s episode of care. Patients need to be re-assessed at least monthly or earlier if the patient’s condition changes.

Certain diseases and treatments such as cancer and mal-absorption syndromes, surgery, radiotherapy and chemotherapy can either reduce absorption of food or increase nutritional requirements. Hypo-albuminaemia (An abnormally low concentration of albumin in the blood) low levels of iron, vitamin A and C and zinc status can all affect the healing rates of wounds.

If specialist advice is required refer to the Community Dietetics Team to arrange a joint visit.

PAIN ASSESSMENT
Pressure ulcers can be a great source of pain and can affect an individual’s quality of life. Pain assessment must include: whether the individual is experiencing pain; the causes of pain; level of pain using a pain assessment chart; as well as location and management interventions. The patient’s pain must be assessed at each visit and a pain assessment chart completed. If pain is not managed effectively then discussion should take place with the patient’s General Practitioner regarding adequate analgesia for pain relief. Assessment should include appropriate repositioning techniques, equipment and pressure relieving devices and any discussions or recommendation must be documented.

INFECTION CONTROL
Chronic wounds often harbour a variety of bacteria to some degree and this can range from contamination through colonisation to infection. When a wound becomes infected it will display the characteristic signs of heat, redness, swelling, pain, heavy exudates and malodour. The patient may also develop generalised pyrexia. However, immuno-suppressed patients, diabetic patients or those on systemic steroid therapy may not present with the classic signs of infection. Instead they may experience delayed wound healing, breakdown of the wound, presence of friable granulation tissue that bleeds easily, increased production of exudates and malodour, and increased pain.

Careful wound assessment is essential to identify potential sites for infection, although routine swabbing of the area is not considered beneficial. If infection is suspected, obtain swab and await results prior to treatment if required.

Contact the TVN and the Infection Control Team if further advice is required.

REPOSITIONING
Patients at risk of pressure ulcer development are repositioned to minimise pressure friction and shearing. The frequency upon which this is done is determined by the patient’s condition, comfort and skin integrity. Evidence to support this action should be in the form of accurate documentation with explicit information regarding:
1. Position
2. Time and Date
3. Members of staff involved
4. Condition of the skin
5. Other nursing care performed
6. Advice to carers
7. Evaluation including repositioning recommendations should be documented.

Repositioning will be detailed in the patients care plan, outlining who will perform the task, how often and what education to carer’s has been given to conduct this safely. Individuals assessed at an elevated risk should consider whether sitting should be restricted to less than 2 hours per session (NICE 2005).

If a patient resides in a residential/nursing home then specific advice to formal carers should be documented in the care plan and evidence that a NICE pressure relieving booklet has been issued to the staff.

RISK ASSESSMENT
Patients who sit out for more than 2 hours have an increased risk of developing pressure ulcers over their ischial tuberosities, natal cleft and sacral areas due to body weight focusing onto these areas.

Patients and carers need to be advised of implications of ‘long term seating’ (Tissue Viability Society 2009) and be educated around alternative positions in the chair, fully document advice in the patients’ records.

Patients assessed as being at risk of pressure ulcer development need to be nursed as a minimum on an Option One mattress (Page 14) as based on pressure ulcer assessment documentation, not solely on the Waterlow Risk Assessment, in conjunction with clinical judgement for which a clear rationale has been documented.

A number of factors need to be considered when deciding on which pressure redistributing mattress to use:-

1. Clinical efficacy
2. Ease of maintenance
3. Impact on nursing procedures
4. Patient acceptability, including manual handling and transfer, double bed, hospital beds
5. Home or care home
6. Ease of use
7. Formal or informal carer providing care

The provision of pressure redistributing equipment should form part of an overall prevention strategy and never as a sole intervention. Regular evaluation of the patient’s skin is required as well as completion of skin integrity check list for nurses or pressure ulcer prevention leaflet for informal carers.

This would be on a conditional basis but thereafter every 3 months, this must include a review of the patient’s pressure redistributing equipment and the reassessment and outcome must be recorded in the patients pressure ulcer documentation.
Equipment is available from the Community Equipment Service and staff must refer for equipment as soon as possible following assessment, for any urgent requests for equipment nurses should contact the community equipment manager for advice.

Community nurses must have a system in the Team in place to monitor that equipment has been provided for the patients, as ordered and subject to ongoing evaluation.

Any problems in obtaining equipment need to be reported on a Trust incident form and discussed with your line manager.

INCIDENT REPORTING OF ALL PRESSURE ULCERS GRADE TWO AND ABOVE
The National Institute for Clinical Guidelines (NICE 2005) recommend that all pressure ulcers graded 2 and above must be reported on a Trust clinical incident form and reported to your line manager. Pressure ulcers grade 2 and above will be reviewed and maybe subject to a root cause analysis, in order to learn from experience and improve patient care.

GENERIC CARE PLANS
- Generic care plans are available on the Trust intranet as outlined in the documentation flowcharts

A detailed care plan must be in the patient’s health records supported by specialist advice from the Tissue Viability Team as appropriate.

SKIN CARE
All patients at risk of pressure ulcer development must have their skin assessed as part of the whole assessment process. This will include general assessment of the skin, but with particular attention to high risk areas, i.e. observation and management of the skin.

<table>
<thead>
<tr>
<th>Heels</th>
<th>Sacrum, natal cleft</th>
<th>Cranium</th>
<th>Skin over ischial tuberosities (particularly relevant for patients who are sat out for prolonged periods)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elbows</td>
<td>Hips</td>
<td>Pinna</td>
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Skin Integrity Check List

Observation and management of the skin integrity will reduce the incidence of skin deterioration and breakdown. Skin inspection and findings must be recorded and documented using skin integrity check list for nurses. Blanching erythema is an indication of early pressure, with timely intervention further damage can be prevented.

Formal or informal carers should be educated on how to inspect the patient’s skin in between episodes of care provided by community nurses. Carers should also be advised that any concerns should be reported to community nurses as soon as possible for reassessment of the patients’ skin condition to prevent further trauma. Carers must be given a copy of ‘Helping to Prevent Pressure Sores’

Examination of erythema should include:
• Apply light finger pressure to the area for 5 seconds
• Release pressure. If the area is white and then return to the original erythema, this can indicate that the superficial circulation remains intact.
• If on release of the pressure the area remains the same colour as before pressure was applied, it is an indication of pressure ulcer development and preventative strategies must be employed (non re-active hyperaemia).
• If further skin discoloration is observed by redness, purple, black or blistering with an increase in heat or swelling, this may indicate deeper tissue damage. This is particularly relevant when induration or hardening of the underlying tissue is palpated. Health care professionals need to be vigilant when caring for patients with darkly pigmented skin. (NICE 2005)

HYGIENE

Over use of soaps and water may undermine skin integrity when combined with urinary and/or faecal incontinence. Urine and faeces can undermine skin integrity through changes in PH and contribute to shear and friction susceptibility. Non soap based foam cleansers are an alternative. Refer to the Clinical Protocol for Skin Care using Emollients and Ointments. (Trust intranet)

CONTINENCE MANAGEMENT

Community Nurses should carry out continence assessments for palliative care patients as required in the Trust Continence Procedure, if any concerns refer to continence specialist nurse for advice and fully document in the health records.

Incontinence may increase the risk of developing pressure ulcers. The key factor is moisture to the skin, which puts it at a greater risk from maceration, friction and shearing forces. Therefore, effective management of incontinence is an essential part of skin care and fundamental to maintaining a person’s dignity and comfort.

MANUAL HANDLING

Manual handling issues relating to the repositioning of patients need to be assessed, involving both informal and formal carers.

Consider the implications for care across a variety of care settings including the independent sector, day and night services as required.

Manual handling risk assessments must be completed if required and any equipment ordered must be documented in the patients’ records and strategies to prevent further damage to the skin as outlined in the patients care plan.

Lifting and manual handling techniques need to be adapted to reduce the risk of shearing and friction. Specific equipment to aid turning should be considered where appropriate, such as slide sheets, transfer board or mobile/static hoist.

Information booklets provided by NICE regarding ‘Pressure Ulcers – Prevention and Treatment’ are available and can be ordered from NICE webpage for patient/carer distribution and must be given to every at risk patient or carer. All bases must hold a stock.

Generic care plan for manual handling for informal carers is available on Trust intranet.
Team leaders/caseload managers must ensure adequate supplies of pressure relieving booklets are available at the base for distribution to patients’.

VULNERABLE ADULTS

In any situation where staff may consider the patient to be a vulnerable adult, they need to follow Trust Vulnerable Adult Policy and discuss with their line manager.

SPECIALIST ADVICE

Contact Specialist Tissue Viability Team for any advice or guidance as required

REFERRALS

Any referrals to therapists or other specialist services must be followed up and all professional advice or guidance documented in the patients health records.

INCIDENT REPORTING

In the event of any clinical incidents or near misses when following this procedure a Trust Incident Form must be completed.

NURSES RESPONSIBILITIES:

- To complete relevant documentation and the relevant pathway followed for the prevention and management of pressure ulcers
- To have care plans for prevention and management of pressure ulcers in the patients health records individualised to the needs of the patient
- When delegating care to formal/informal carers care plans will be in the health records individualised to the needs of the patient
- To complete incident forms for grade two and above pressure ulcers

TEAM LEADERS RESPONSIBILITIES:

- To comply with audits undertaken by Tissue Viability Specialist Team or other nominated audit lead
- To monitor compliance with this procedure
- To keep a record of staff attendance at Tissue Viability Training

CONSULTATION PROCESS

- Infection Control team
- Clinical Procedure Group
- Tissue Viability Team
- Quality and Governance Service
EUROPEAN PRESSURE ULCER ADVISORY PANEL (EPUAP)
PRESSURE ULCER CLASSIFICATION (NICE 2005)

**CLASSIFICATION**

<table>
<thead>
<tr>
<th>Grade 1:</th>
<th>Non- Blanchable erythema of intact skin. Discolouration of the skin, warmth, oedema, induration or hardness, may also be used as indicators, particularly on individuals with darker skin.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grade 2:</td>
<td>Partial thickness skin loss involving epidermis, dermis or both. The ulcer is superficial and presents clinically as an abrasion or blister</td>
</tr>
<tr>
<td>Grade 3:</td>
<td>Full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to but not through underlying fascia</td>
</tr>
<tr>
<td>Grade 4:</td>
<td>Extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures with or without full thickness skin loss</td>
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</table>

**TREATMENT OF PRESSURE ULCERS**
*(DRESSINGS TAKEN FROM CURRENT WOUND PRODUCT GUIDELINES)*

<table>
<thead>
<tr>
<th>Grade 1:</th>
<th>Protect skin: Hydrocolloid, film dressing or skin protectant. Appropriate skin hygiene. Continenence management. Eliminate friction &amp; shear, review manual handling</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grade 2:</td>
<td>Hydrocolloid, Foam. Record as critical incident all grade 2 and above</td>
</tr>
<tr>
<td>Grade 3:</td>
<td>Aquacel*, Hydrocolloid (Versiva) Foam, Tielle Biatain (Exudate dependent) Alione.</td>
</tr>
<tr>
<td>Grade 4:</td>
<td>Aquacel* / Versiva: Foam Tielle Plus, Biatain, Alione</td>
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<td>Infection will require systemic antibiotics &amp; topical antimicrobial e.g. Aquacel AG evaluate weekly</td>
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**PRESSURE REDISTRIBUTION CUSHION OPTIONS**

For mattress selection or cushion assessment complete a formal assessment that needs to consider distribution of weight, postural alignment and support of feet. Even with appropriate pressure relief, it may be necessary to restrict sitting time to a maximum of 2 hours until the level of risk changes. Although there has been guidance from the National Institute of Clinical Excellence (NICE 2005) with regards to the minimum mattress provision, there is no such guidance for cushions only that no one seat cushion has been proven to perform better than another.

<table>
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<tr>
<th>CUSHION PROVISION – AT RISK TO ELEVATED RISK</th>
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<tbody>
<tr>
<td>Cushion Gel / foam mix</td>
<td>e.g. Dyna –Tek / Posture Visco</td>
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<tr>
<td>Grades 1 – 4 EPUAP</td>
<td>(European Pressure Ulcer Advisory Panel)</td>
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PROCEDURE FOR PRESSURE ULCER PREVENTION AND MANAGEMENT

13/17
Clear guideline instructions are provided with all mattresses from Community Equipment Service. Some patients may require specialist seating assessment (Tissue Viability Society 2009), nurses need to consider referral to appropriate services for example occupational therapist or wheelchair centre.

PRESSURE REDISTRIBUTING EQUIPMENT OPTIONS

Selection should be based on a formal assessment process. Clinical judgement remains the main basis for determining level of risk. Consideration should be given to:
- repositioning,
- seating,
- skin inspection

All patients assessed as being vulnerable to pressure ulcers should, as a minimum provision, be placed on a high specification foam mattress with pressure-relieving properties (NICE 2005) (II) Option ①

An alternating system or other high-tech pressure relieving system should be employed, under the following criteria
- As a first line preventative strategy for people at risk as identified by assessment.
- When the individual’s previous history of pressure ulcer prevention and/or clinical condition indicates that he or she is best cared for on a high tech device.
- When a low tech device has failed (NICE 2005) (III) Option ②

<table>
<thead>
<tr>
<th>MATTRESS STATUS</th>
<th>MATTRESS</th>
<th>STATUS</th>
<th>RISK</th>
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<tbody>
<tr>
<td>Softform Premier replacement</td>
<td>Replacement mattress foam</td>
<td>High Risk Grade 1 - 2</td>
<td>Cairwave Pegasus Ltd Replacement</td>
</tr>
<tr>
<td>Dyna – Form Mercury</td>
<td>Replacement mattress foam</td>
<td>High Risk Grade 1 - 2</td>
<td>Nimbus 3 Huntleigh Replacement</td>
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<td>Bi-wave Pegasus Ltd Replacement</td>
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<td>Phase 2 &amp; Elite Park House Replacement</td>
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<td>Dyna – Form Air Plus Replacement</td>
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PROCEDURE FOR PRESSURE ULCER PREVENTION AND MANAGEMENT

ALL NEW PATIENTS ON THE CASELOAD

APPENDIX 2

FLOW CHART 1 – FOR PREVENTION OF PRESSURE ULCERS

Complete the following documentation

INITIAL ASSESSMENT COMMUNITY NURSING
or Palliative Care Assessment Documentation when launched

Complete Pressure Ulcer and Nutrition Risk Assessment
Is patient at risk?

Yes

Not at risk of pressure ulcer development
No

Complete the following:
• Section One Pressure Ulcer Assessment
• Manual handling assessment *(if required)*
• Complete body map

IF WATERLOW 10 or more and patient clinically assessed as being at risk of pressure ulcer development
Put the following in place and individualise to patients needs:
• Care plan for the Prevention of Pressure Ulcers
• Appropriate Care Plan for Prevention of Pressure Ulcers for either Formal / Informal carers *(if required)*
• Care plan for manual handling for informal carers *(if needed)*
• Consider care plan for nutritional support
• Consider pain assessment chart
• Consider frequency of completing skin integrity check list

IF PATIENT DEVELOPS A PRESSURE ULCER FOLLOW Flow Chart 2 (APPENDIX 3)

If Waterlow score is around 10 and health professional considers patient not at risk of pressure ulcer development, this must be recorded on initial assessment documentation
FLOW CHART 2 – FOR THE ASSESSMENT AND MANAGEMENT OF PATIENTS WITH EXISTING OR NEW PRESSURE ULCERS

Complete the following documentation:

- Complete Initial Assessment Community Nursing documentation
- Comprehensive Nursing Overview
- Complete Pressure Ulcer and Nutrition Risk Assessment
- Complete manual handling assessment (if required)
- Complete prevention and management of pressure ulcer assessment form section one and section two
- Complete body map
- Complete skin integrity checklist – as required
- Pain assessment chart

Commence the following care plans to meet the patient’s clinical needs:

- Care plan for the Management of Pressure Ulcers (each pressure ulcer must have an individual care plan)
- Appropriate Care Plan for Prevention of Pressure Ulcers for either Formal / Informal carers
- Care plan for delegating Manual Handling Activities for Informal carers (if required)
- Care plan for nutritional support (if required)
- Consider frequency of completing skin integrity check list

REFER TO TISSUE VIABILITY SERVICE (If required)
REFERENCES

Clinical Protocol. Skin Care using Emollients & Ointments. Use current version of Wirral Community NHS Trust

Commissioning for Quality and Innovation (DH 2008)


National Institute of Clinical Excellence (NICE) The Management of Pressure Ulcers in Primary & Secondary Care: A Clinical Practice Guideline (September 2005) in collaboration with the Royal Collage of Nursing (RCN)

National Pressure Ulcer Advisory Panel (NPUAP) July 2007 http://www.npuap.org/print.htm


Safe Guarding Adults Policy. Use current version of Wirral Community NHS Trust


BIBLIOGRAPHY

Essence of Care: Patient focused benchmarks for Health care Practitioners. Pressure Ulcers. DH Publication. 2010.